LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV HEALTH SERVICES
ANNUAL MEETING MINUTES
November 14-15, 2005

DAY 1: NOVEMBER 14, 2005			
MEMBERS PRESENT	**MEMBERS PRESENT *(cont.)***	**PUBLIC**	**COMM STAFF/ CONSULTANTS**
Al Ballesteros, *Co-Chair*	Everado Orozco	Genevieve Clavreul	Mario Almanza
Nettie DeAugustine, *Co-Chair*	Dean Page	Richard Eastman	Virginia Bonila
Carla Bailey	Angelica Palmeros		Diane Burbie
Carrie Broadus	Gloria Perez		Gary Garcia
Robert Butler	Wendy Schwartz	**OAPP STAFF**	Jane Nachazel
Charles Carter	Andrew Signey		Arlene Narvaez
Mario Chavez	James Skinner	Chi-Wai Au	Glenda Pinney
Alicia Crews-Rhoden	Ron Snyder	Michael Green	Elizabeth Ramos
Whitney Engeran	Gary Vrooman	Jan King	Lisa Ransdell
Hugo Farias	Kathy Watt	Soraya Montoya	Doris Reed
Douglas Frye		Mario Perez	Deborah Silver
William Fuentes	**MEMBERS ABSENT**	Diana Vasquez	Jim Stewart
David Giugni		Juhua Wu	Beverly Voran
Terry Goddard	Ruben Acosta		Craig Vincent-Jones
Elizabeth Gomez	Adrian Aguilar		Nicole Werner
Jeffrey Goodman	Daisy Aguirre		
Richard Hamilton	Anthony Braswell		
Precious Jackson	John Griggs		
Marcy Kaplan	Quentin O'Brien		
Brad Land	Carlos Peralta		
Kevin Lewis	Jonathan Stockton		
Anna Long	Peg Taylor		
Davyd McCoy	Jocelyn Woodward		
Susan McGinnis	Fariba Younai		
Ruel Nolledo			

I. **REGISTRATION/CONTINENTAL BREAKFAST**: Participants convened at 8:30 am, the first day, November 14, 2005.

II. **CALL TO ORDER**

A. Roll Call/Introductions: Ms. DeAugustine and Mr. Ballesteros called the meeting to order at 9:30 am. Mr. Vincent-Jones called the roll.

III. **WELCOME**

A. Review of Accomplishments: Ms. DeAugustine and Mr. Ballesteros welcomed attendees. They then called attention to accomplishments of the past year:

- Conducted Commission orientation for the Service Provider Networks (SPNs);
- Launched Strategic Planning Process that will ultimately lead to a new Comprehensive Care Plan;
- Continued support for Cross-Title Collaborative;
- Will have completed a Memorandum of Understanding (MOU) draft with the Office of AIDS Programs and Policy (OAPP) to outline the Commission's working relationship with OAPP;
- Implemented Commission staffing;
- Completed the first full multi-month Priority- and Allocation-Setting Process (for Year 16);
- Established and launched the five-month Priority- and Allocation-Setting Process framework;
- Designed collaborative working partnerships with the Service Provider Networks (SPNs);
- Established Program Support, Geographic Estimate of Need (GEN) and Minority AIDS Initiative (MAI) Subcommittees that will complete their recommendations by the end of the year;
- Conducted the second consecutive year of the HIV-Care Assessment Project (H-CAP);
- Prompted the Los Angeles County's co-sponsorship of SB-945, helping to lead a statewide coalition advocating the conversion to names-based HIV reporting, with expected re-introduction of bill in January 2006;
- Developed a CARE Act Reauthorization policy used to educate stakeholders, which resulted, in part, in Board of Supervisors (Board) agreement to advocate for the preservation of Planning Councils;
- Led the State of California's (State's) nine planning councils in unanimous opinions about CARE Act reauthorization and names-based HIV reporting;
- Visited all local delegation District Congressional Offices and majority of County and State legislative Offices;
- Launched HIV Housing Task Force;
- Initiated Standards Development Process (SDP), resulting in adoption of Standards of Care for more than half of the funded service categories with the rest in progress;
- Finalized Standards of Care dissemination process;
- Launched Health System Task Force;
- Re-wrote Commission County Ordinance adopted by the Board;
- Re-wrote Commission Bylaws;
- Established Policies and Procedures Manual;
- Launched Commission website;
- Identified, recruited and installed new Commission membership;
- Developed and implemented new, comprehensive Commissioner training;
- Finalized third Assessment of the Administrative Mechanism (AAM) with a new evaluation methodology, enhancing partnership of OAPP and Commission;
- Concluded an RFP process resulting in selection of a two-year AAM consultant; and
- Defined and implemented an ongoing AAM recommendation and follow-up strategy.

IV. **GREETINGS**

A. HIV/AIDS Bureau (HAB) Dialogue: Mr. Vincent-Jones introduced a conference call with Lorenzo Taylor, LA County's Title I Project Officer, and Douglas Morgan, Director, Division of Social Services, HIV/AIDS Bureau (HAB). Mr. Vincent-Jones noted that the Commission's previous Project Officer, Jo Messore, had been promoted and Mr. Taylor is her successor. He thanked her, Mssrs. Morgan and Taylor, and HRSA staff for their invaluable assistance.

- Mr. Morgan commended the Commission for its work and its ability to work effectively in partnership with OAPP. Mr. Lorenzo complemented the Commission and OAPP, and noted his transition had been a smooth one.

- Mr. Land thanked Mr. Morgan and Mr. Lorenzo for their participation. He said he had attended a Reauthorization Town Hall Meeting the week prior and had felt the emphasis suggested poor prospects for Reauthorization and adequate funding. He noted that West Coast states have a more geographically dispersed epidemic and affected populations than such concentrated areas as New York and expressed concern that funding meet that need.
- Mr. Morgan said he had participated in a Reauthorization Town Hall in Chicago that included consumers and providers. He expressed confidence that concerns, issues and suggestions raised here would be brought back to HRSA. He also noted that the Federal Reauthorization Principles released for discussion were Principles that had not yet been fleshed out or as yet embodied in a bill. He said the expectation was that the CARE Act would be reauthorized, probably in 2006, but it was impossible to estimate how the Principles will impact legislative language. Meanwhile, he added, the program will continue until the governance of current legislation.
- Ms. Watt echoed that the participants in UCHAPS had expressed concern that there had not been enough notice for the Town Halls, and, as a result, they were rendered ineffective. Mr. Morgan said HAB did not develop the format, though he added there had been a concern to obtain input quickly.
- Regarding funding, Mr. Morgan noted the President's proposed Fiscal Year (FY) 2006 budget included no increase in HIV/AIDS funding except for ADAP. The FY 2007 budget has not been proposed as yet. The forums were designed to be a conduit for information to the process as a whole.
- Mr. Ballesteros commented that the primary theme from the HRSA folks at the Town Halls seemed to focus on disbursing funding to other areas of the country, where, it has been perceived, have been less well served. While he appreciates the Maintenance Of Effort (MOE) and support for services in this area, he is concerned that people understand the epidemic is severe here, not withstanding the needs elsewhere. He encouraged that, going forward, local and state governments of other districts ought be encouraged to contribute their fair share as well.
- Ms. DeAugustine complemented Mr. Morgan on his earlier candor in responding to the rumors that some were thinking about abolishing planning councils, which had allowed the Commission to responsibly address those concerns. She commented that, while HRSA had been very helpful in providing Technical Assistance (TA) to planning councils, TA could be enhanced to support development of planning councils so that they can be more effective. Mr. Morgan responded that they support TA, but have also been limited in funding. Mr. Taylor added that it is helpful when EMAs assume TA, as LA has done with much of its TA, to make it a part of their process.
- Mr. Vincent-Jones asked about the Federal sense, and the overall national sense, about the Reauthorization subject of changing planning councils to voluntary. Mr. Morgan responded that the issue initially developed because of uneven performance of EMAs nationally. He said the basic voluntary planning council principle has been gaining "traction" in Washington and, while he could not know for certain, he would not be surprised to find some variant of it in the final bill. It is his hope that, in places like Los Angeles where the model has been effective, it can be maintained. If the final bill provides an option, he said it will be HAB's job to determine how best to implement it and provide guidance.
- Mr. Butler asked if there has been any sense of the relationship of HIV names-based reporting to Reauthorization, especially as to its acceptance nationally and whether it might be written into the CARE Act. Regarding HIV names-based reporting, Mr. Morgan pointed out that the current CARE Act stipulated that HRSA would begin to use this data in funding formulas as early as 2005 and no later than 2007. Given that language, HRSA is currently looking at how to integrate HIV reporting into formula calculations in 2007. All states now have some form of HIV reporting system.
- Mr. Vincent-Jones clarified that California cannot move to HIV names-based reporting until legislation is approved and signed by the Governor. While emergency legislation is anticipated here in January, a transition plan will be necessary to ensure that the 12 or so states that have been using code-based or code-to-name reporting will have time to catch up to other states in reliability. It will not be possible for them to meet the same standard of data by October 2006. He asked if the CDC was addressing that issue. Mr. Morgan responded that HRSA is working closely with the epidemiology side of CDC to incorporate HIV data in a fair and understandable manner. He went on to say HRSA's discussions with CDC are addressing the fact that it normally takes a couple years for a reporting system to mature. Obviously, if California begins an HIV names-based program in early 2006, data will not be of the same level as more mature systems. The CDC surveillance branch is looking at that issue.
- Mr. Butler also asked how Behavioral Risk Groups (BRGs) were being viewed. He said that, especially in the communities of color he represents, the traditional high risk groups do not represent many of those now testing positive, particularly women. Mr. Morgan said he was aware that HAB is concerned about the BRG issue and is working with the CDC) on it. Many new prevention intervention models are being evaluated. HIV names-based reporting will help in better targeting these newer risk groups by identifying trends earlier. The Prevention With Positives initiative also can assist in protecting these populations.

- Mr. Vincent-Jones asked for guidance on preparation of implementation of Medicare Part D. Mr. Morgan said that HAB had been addressing the issue as early as last year, before the discount cards became available. He and other representatives have participated in work groups with CMS. There are some Q & As, that are being revised regularly, on the website address frequently raised questions. It is suggested generally that, due to the complexities of the program, EMAs work closely with their state ADAPs who are accustomed to working with pharmacies in their areas. While those who are eligible are automatically being moved to Medicare Part D as of January, those who fall in the 100-150% of poverty present some possibilities and concerns, as well as those above that who may also be eligible for Part D.

V. **APPROVAL OF AGENDA**

A. Agenda Introduction and Review: Ms. DeAugstine presented the agenda for approval.
MOTION #1: Agenda Order approved ***(Passed by Consensus)***.

VI. **APPROVAL OF MEETING MINUTES**

A. October 13, 2005: Ms. DeAugustine presented the minutes for approval.
MOTION #2: October 13, 2005 meeting minutes approved ***(Passed by Consensus)***.

VII. **PUBLIC COMMENT, NON-AGENDIZED**: There was no non-agendized public comment.

VIII. **COMMISSION COMMENT, NON AGENDIZED**: Mr. Land asked to the group to keep John Griggs in their thoughts. He is hospitalized in the ICU, but called to express his regrets at being unable to attend the meeting and wished everyone well. Ms. DeAugustine congratulated Mr. Griggs for his many contributions to the Commission.

IX. **CO-CHAIRS REPORT**

A. Conflict of Interest Policy/Procedure: Ms. DeAugustine noted that after the October meeting, which included a great deal of discussion on contract amounts and two motions, there were several meetings with OAPP, Department of Health Services (DHS) and County Counsel regarding possible conflict of interest. Mr. Vincent-Jones reported on the discussions about the Commission actions and the newly proposed Conflict of Interest Policy/Procedure.

- He noted that the two recommendations to the Board and DHS that the Commission voted on raised concerns about providers who might be impacted by the cutbacks voting on the recommendations but having a conflict of interest. The issue was forwarded to County Counsel. County Counsel responded with the opinion that a conflict of interest for those providers did exist.
- Mr. Vincent-Jones suggested two approaches to address the issue: 1) a conflict of interest policy/procedure to clarify such situations in future, and 2) re-introduction of the two October motions for re-consideration and voting by those Commissioners not at conflict of interest.
- He provided background on the conflict of interest issue. Some years back, prior to his arrival and unbeknownst to him, County Counsel had notified the Commission of pertinent rules based on the State Political Reform Act and Government Code 1090. Both proscribe conflict of interest for government officials who have a financial interest in a decision. Commissioners are deemed government officials, both because the Commission has actual decision-making authority and because it influences other public bodies like the Board. Essentially, if a Commissioner or his/her employer will be financially impacted by a decision that is being acted upon, the Commissioner should recuse him/herself from that discussion and vote. This is a complex situation for the Commission since the CARE Act requires providers to be at the table and participate in these types of decisions. Since Federal law preempts State law, Commissioners are expected to participate and vote in cases like Priority- and Allocation-Setting, Comprehensive Care Plan development, service effectiveness and AAM which are federally mandated, regardless of their possible conflict of interest. When voting on issues required by Federal law, Commissioners have "safe harbor" from the State's conflict of interest laws.
- The draft policy/procedure spells out three tiers of conflict of interest: 1) financial impact regarding non-federally mandated role requires the Commissioner to recuse him/herself and move to the public area where he/she may speak as a member of the public only; 2) financial impact regarding a non-federally mandated role when conflict is only recognized after discussion has already been initiated requires the Commissioner to abstain; 3) financial impact regarding federally mandated role requires the Commissioner to identify his/her potential conflict of interest in both conversation and voting.
- Ms. Kaplan felt the Parliamentarian should play a greater role. She noted funding reductionss will always be of general concern to all Commissioners. Mr. Vincent-Jones reminded the Commission that Mr. Stewart had, from the beginning, noted that he was not an attorney and could not rule on Brown Act or conflict of interest laws. However, the policy/procedure will provide him guidance to assist the Commission in that regard, as well as provide the added

component of authority to the "presiding officer" (co-chairs, parliamentarian, for example) to raise the issue of conflict of interest anytime it is deemed appropriate.

- Ms. DeAugustine commented that the Commission has voted on such issues in the past. That point was raised to County Counsel. Their concern was the distinction concerning specific contracts, and that these votes were not necessarily related to the Commission's federally-required planning council role, but as an advisory body to the Board.
- Mr. Perez noted that the recommended cuts included very specific contract percentage reductions that were easily calculable. Dollar amounts per contract could, therefore, be determined by voting Commissioners creating a different level of conflict of interest than would have been the case had amounts been category generic. Mr. Vincent-Jones agreed with Mr. Perez, but noted that the Federal "safe harbor" for Priority- and Allocation-Setting remains even in those cases, for example, where a service category has only one provider who could identify a financial impact should that category by reduction.
- Mr. Land said that, as someone whose effective income will be keenly affected by Medicare Plan D, he feels many issues address areas that directly affect consumers, and asked why consumers are not subject to conflict of interest rules as well. Mr. Vincent-Jones responded that he had raised that issue with County Counsel, but the conflict of interest legislation narrowly defines "financial interest". Mr. Stewart noted that consumers are not affected since the assumption is that, if a service is not provided through one source, it will be provided through another source.
- Mr. Butler commented that the issue should not be over-thought. On one hand, everyone at the table has some conflict of interest from one perspective. However, conflicts are and will be dealt with through the Executive Committee, the Parliamentarian, Co-Chairs and staff, as well as Commission parliamentarian trainings. Two more parliamentarian trainings are planned for January. It should be remembered that the Commission has responsibilities to both the CARE Act and the County, so these issues will come up and be handled as necessary. He suggested the policy be left open for 30-day public comment. Ms. DeAugustine agreed and thanked those who brought the issue to the table for calling it to the Commission's attention. So, moving forward, the Commission will frame, discuss and vote on issues more carefully in light of the Commission's charges under both the CARE Act and the County Ordinance.
- Mr. Hamilton said the discussion is helpful in better defining his role. He noted that, as a Health Educator with Minority AIDS Project and the SPA 6 Provider Commission Representative, he often is not certain if his provider would be affected by a particular vote. The Co-Chairs agreed to discuss types of scenarios in the Executive Committee to better understand their impact. Ms. Watt suggested each Commissioner with a provider acquaint him/herself with that provider's services to better understand when a contract might affect the provider.

MOTION #3: Introduce the Conflict of Interest Policy/Procedure for 30-day Public Comment ***(Passed by Consensus)***.

B. Proposed Contract Reductions from OAPP: Following from the preceding discussion, Mr. Vincent-Jones presented the motions for review. The Co-Chairs asked the Executive Director and Parliamentarian to lead this topic, as they recused themselves.

- The first recommendation was that the proposed service cutbacks be rejected and an alternative plan be brought forward. It was not judged or articulated as part of the Commission's Priority- and Allocation-Setting responsibility. County Counsel, with Mr. Vincent-Jones' assent, felt that it was, therefore, not covered as a federally mandated vote. Providers with a potentially impacted contract should, therefore, recuse themselves from the conversation and vote.
- The second recommendation was that information used by OAPP to make budgets, including Net County Cost (NCC), be revealed on a consistent basis so that the Commission could use it in its Priority- and Allocation-Setting process. The way the motion was phrased, County Counsel felt it was part of the first motion, though the conversation surrounding it clearly indicated that it was designed to support the priority- and allocation-Setting process. It has, therefore, been rephrased to emphasize that linkage to priority- and allocation-setting.
- Mr. Perez noted there are letters in the packet forwarded by OAPP reflecting the development of the recommendations and the Board response. An additional letter, not in the packet, was sent to all providers the prior Tuesday. It reflects the current plan to move forward in negotiating all Year 16 contracts at the Year 15 levels. That is, no reductions are planned to any of the seven service categories talked about last month, although OAPP has not yet identified funding to compensate for the shortfall.
- Mr. Stewart noted that, since both Co-Chairs are conflicted, he would assume leadership of the discussion. He added that quorum consists of a majority of people among those not recused.

MOTION #4: Recommend that the Board of Supervisors and the Department of Health Services (DHS) reject the proposed service reductions, as detailed in communications by the Office of AIDS Programs and Policy (OAPP), and instruct DHS and

OAPP to develop an alternative solution within 30 days (for presentation by the next Commission meeting on December 8, 2005), based on a thorough analysis of all of the administrative items ***(Passed: Ayes - 12; Opposed - O; Abstentions - 10)***.

- Mr. Vincent-Jones said the second motion is deemed to be part of the Priority- and Allocation-Setting process, and, thus, recusal was not be necessary for provider-affiliated commissioners. The Co-Chairs resumed leadership of the meeting. It was agreed to use a role-call vote. Per the proposed conflict of interest policy, affiliated Commissioners were instructed to state their affiliation when voting, following the Commission's usual priority- and allocation-Setting practice.

MOTION #5: As a Priority- and Allocation-Setting measure, and unrelated to recommendations in response to proposed Year 16 contract reductions, recommend that the Board of Supervisors and the Department of Health Services (DHS) instruct the Office of AIDS Programs and Policy (OAPP) to provide the Commission on HIV, within 30 days, OAPP's current fiscal year operational budget, ending June 30, 2006. Further, OAPP should be instructed to provide all associated documents, projections, process and methodology used in the creation of the subsequent FY budget beginning on July 1, 2007. This should include relevant OAPP contracted information from all parts of the CARE Act, NCC, cooperative agreements and other sources of funds ***(Passed: Ayes - 22; Opposed – O; Abstentions - 1)***.

- Mr. Perez said he felt he had made a commitment to be transparent and forthcoming and create a constructive dialogue with the Commission. He found the spirit of the motions inconsistent with his expectations to forge a different relationship with this community planning body. He felt his earlier statement affirming no contract reductions as of March 1 fell on deaf ears, with the Commission moving forward with a motion (Motion #4) he felt was moot. While he understood there had been some delays in the Commission obtaining information requested in Motion #5, he felt it did not help develop a constructive relationship with OAPP for the Commission to continue to go to the Board and DHS for instructions to OAPP on everything needed. He felt such requests should be handled directly between OAPP and the Commission. He added he has made a commitment to Mr. Vincent-Jones to have a different spirit guide the relationship.
- Ms. DeAugustine said she appreciated his remarks on the new spirit. Even so, the items reflected had been requested over years without result. She felt the motions were appropriate until history catches up with that spirit. She added that Mr. Perez has breathed a breath of fresh air into the relationship and noted that some of the historical problems have been with DHS, not OAPP. Ms. Kaplan felt the motions needed to be done simply as do-over to resolve the previous votes. At the same time, she felt it was important to express appreciation for Mr. Perez and his staff, especially in respect to the additional work created by putting the contracts on hold.
- Mr. Vincent-Jones agreed with Ms. Kaplan's expression of appreciation. He noted, however, that it was important for the Commission to correct its prior votes, in order to address any lingering perceptions about the Commission's original intent. He added that for the record, it was important that the Commission clarify its interests in the matter, and ensure the community that they had not changed even though some of the people originally voting on the issue had been since advised to recuse themselves. He agreed that much of the matters were already addressed, and, as a result, the votes did not necessitate or anticipate another letter reaffirming the vote.

X. PUBLIC POLICY COMMITTEE REPORT

A. Reauthorization: Consolidated Statement from the State's Planning Councils: Mr. Engeran presented a consolidated statement from all the California planning councils on Reauthorization, for approval. He noted that it was in the packet and that, in the course of its development over the last few months, it had come before the Commission several times in earlier iterations, but the Commission had not had the time to discuss it. It follows the format of responding to the Federal Reauthorization Principles and addresses the most significant ones for California. He noted the other planning councils have already approved it. Mr. Page asked if it addressed protection of the Federal mandate for planning councils. Mr. Engeran responded there was no unanimity on the issue, but the document emphasizes the importance of community planning.
MOTION #6: Approve the Consolidated Statement on CARE Act Reauthorization in conjunction with the State's planning councils ***(Passed by Consensus)***.

XII. PRIORITIES AND PLANNING (P&P) COMMITTEE REPORT

A. Medicare Part D Implementation:

- Ms. DeAugustine introduced the subject. She expressed even her own staff's concern about their ability to provide appropriate help to those they serve, and hoped that this would be an attempt to assist that effort.
- Mr. Vincent-Jones noted there are recommendations in the packet from both the Finance Committee and the P&P Committee. He added that they were, in some cases, contradictory, but the Executive Committee has agreed to collaborate with OAPP on the training and education pieces of this on which there is agreement. That process is moving forward. He went on to indicate that a second part of the process is policy. The Public Policy Committee will take up the question

of whether CARE HIPP funds can be allocated and used to fund premiums. The third part of the process deals with allocations. The question is whether there are any decisions the Commission needs to make or actions it needs to take that will adjust the Year 16 allocations. He noted that Medicare Part D will cover the last two months of Year 15, January and February, as well as Year 16. The Year 15 months could, in fact, be the hardest months.

- He further explained that the two central problems for consumers appear to be that State ADAP will not be paying for premiums and, for some consumers, share of costs (or the "donut hole"). So, on entry into the system, and on its higher level, there has been no reimbursement identified. ADAP will pay for co-pays and deductibles. If the Commission chooses to pay for premiums, it would have to determine equity in determining which premiums would be eligible. That decision must be made in the context that there are at least 25 plans offered in LA County that do not charge premiums.
- If it is decided to pay premiums, it would be necessary to quickly determine how to fund them. Could OAPP quickly initiate an adjudication function to facilitate their payment and, if so, how would the premiums be funded and could Title I service dollars be used for the administrative expense? Or, would OAPP have to do so through emergency financial assistance. Regarding share of cost, would it apply to services and/or clients not previously funded in the system? Also, certain classes of clients lose Denti-Cal and vision care if they lose MediCal, which could increase the load on comparable Title I services and, in turn, potentially impact allocations to those services.
- Mr. Butler noted the Executive Committee had considered directing the Finance Committee to develop various scenarios. Mr. Butler also noted some of his consumers are receiving letters from Medicare saying that, if they don't select a Medicare Advantage managed care program, one will be selected for them. He added some of the programs have not released much detail on the programs.
- Mr. Ballesteros said that ADAP has paid to fill medications on the 1st of the month, then the providers bill for share of cost based on that for the rest of the month. With ADAP no longer doing that, the effect on providers could be massive. Ms. Watt reminded that funds moved to compensate for expenses would have a trickle-down effect somewhere elsewhere.
- Mr. Engeran pointed out that there is no emergency financial assistance service category. He also noted it is important to consider what precedent would be set if the Commission began to backfill funds, especially when Title I funds are likely to be reduced.
- Mr. Goodman said he went to the Medicare website and put in five profiles, including his own. For his zip code, 68 drug plans came up with so much information he was unable to make a decision. He said the top 15% of those receiving Social Security income will be hardest hit, especially those at the 150% of poverty or who have gone back to work.
- Mr. Land said he is most concerned about the share of cost being evaluated by premium, as well as the effect on cost of living. He recommended a study of cost of living per SPA as they effect the consumers' ability to incorporate premiums. While he is concerned about presenting a message that expenses can always be compensated, he is also concerned about sending a message that some people can be cut adrift from care to perish.
- Ms. Bailey said she understood that AIDS drugs are on all the formulas, but she is concerned about other medications that may support treatment and may not be on the formulary. She added that she felt it would be fruitless to develop a plan until funding availability is known.
- Mr. Chavez said he went to APLA for assistance and they could not find a plan that covers all of his medications. He said his Social Security increases each year, but so does his share of cost, so that his living expenses remain the same.
- Mr. Perez said OAPP was convening a group of local experts, in particular to review eight areas like Year 15 and Year 16 allocations, evaluation and share of cost. He felt it was a bit premature to begin looking at Year 16 allocations. First, he would like to see more pressure on the State to cover more of these expenses. A significant area of concern is share of cost paid, particularly by dual eligibles. Mr. Perez went on to say that once a solid implementation plan has been developed, there needs to be an aggressive training and education plan. He noted that training will encompass numerous people and venues, like case managers, ADAP enrollment sites, treatment educators, medical providers. He suggested moving the motion's timeline up to the December 8th Commission meeting.
- Ms. Palmeros said the City of Pasadena has an ADAP enrollment site. They are considering identifying those who need to enroll and help them get the best plan for them, as well as ensuring they get three months of medications from ADAP to stretch those resources as far as possible. She added that they are also working with other groups to assist other affected populations, like the elderly. She added that ADAP had told them they would try to continue to cover medications that will no longer be covered by new plans.
- Mr. Butler commented that ADAP is now considering the entire Medi-Cal formulary as covered, so medications dropped from Medicare could be picked up by ADAP. Mr. Engeran noted that CARE HIPP has traditionally been underfunded. That could be a logical place for premiums to be paid. He recommended that Public Policy open a discussion of how

that might be pursued with the State. Ms. Jackson suggested the pharmaceutical companies might be requested to cover share of cost for their medications. Mr. Skinner said he had heard that Social Security benefits might be increasing. It was agreed that could move someone into a higher share of cost situation.

- Ms. Schwartz suggested an implementation plan could be more readily developed in a smaller group. Dr. King said there was a work group that would be meeting before Thanksgiving. Several representatives from the Commission were invited. Ms. DeAugustine added that she and Mr. Perez would be joining other AIDS directors from the State in Sacramento for a two-day meeting to listen to and provide input for a statewide approach.

MOTION #7 ***(Engeran/Butler)*** : Instruct the P&P and Finance Committees to continue monitoring the Medicare Plan D situation and fully develop cost recovery scenarios, and for staff to work with OAPP to develop an implementation plan and recommendations by the December 8, 2005 Commission Meeting ***(Passed by Consensus)***

XIV. **IMPLEMENTATION PLAN DEVELOPMENT**: Dr. Green presented the Ryan White CARE Act Title I Implementation Plan. He utilized a PowerPoint and the Care Act Table 3 of service goals also provided in the packet.

- Three plans are developed each year: 1) service goals for the application; 2) a plan adjusted to the award; 3) actual utilization at the end of the year.
- While previously all service categories had to be described for the application, now only the top six categories prioritized by the Commission need to be. The description includes the service definition, goals and numbers served. The second and third implementation plans do need to reflect all prioritized service categories, whether or not they were funded.
- The application requires epidemiology and service utilization documentation to show why funds are being used as they are and make the best case for funding.
- The process is very collaborative, based on the Comprehensive Care Plan, priority- and allocation-setting, standards of care, Commission recommendations on service goals and incorporating information developed on other sources of funding when possible, and service utilization information from the providers. Currently, additional supportive information is being developed and generated from CaseWatch.
- Plan development must follow HRSA Guidance, from its goal of 100% access and 0 disparity to such practical matters as format and page limits which restrict the amount of information that can be submitted. Tables are used because they most efficiently provide as much data as possible.
- Service delivery numbers must be estimated, based on those already being served and estimates of need. Because the application is designed to request as much justifiable funding as possible, it is important to represent the need well.
- The process continues cyclically throughout the year, engaging the Commission, Title I-funded agencies and OAPP working with HRSA and, though not required, Title II-funded agencies.
- HRSA also expects to see challenges identified and addressed. For example, one year a challenge was identified in providing dental services in some areas. The challenge was addressed the next year by funding a dental mobile van.
- Each year the application guidance details the Conditions of Award (COAs) that will be required, for example, the second and third implementation plans. In the past, points were associated with the COAs that could count against the next year's award. OAPP has asked twice for written clarification of the current policy, but has received no response. It has been vaguely alluded to, however, that there could be funding implications if COAs are not met.
- Documenting the EMAs description of and response to severe need is a critical aspect of the process.
- Mr. Butler noted that the monthly report information currently takes about 45 days and asked if CaseWatch improves that time lag. Dr. Green noted that CaseWatch is designed as a real-time system, though it is not yet fully functional.
- Ms. Watt asked why, if more people are coming into the system and fewer leaving it, this year's request for $48 million is almost the same as last year's request for $47 million. Dr. Green noted that last year's request had been justified differently. Data from previous year is prorated, look at the data collected and then work backwards into the numbers for service categories based on the Commission's priority- and allocation-setting.
- Ms. Watt said a better understanding of prevention and education goals feed into the process. Dr. Green agreed, but noted the contradiction in that better prevention and education (as the CDC wants) creates greater demand (which HRSA is not supporting). Unmet need data is garnered primarily from the CDC. While some EMAs develop their own, they then have to defend the data. Using the Federal government's own numbers where possible fosters their acceptance.
- Usually the Notice of Award is received in January or February. If it is noticeably different than anticipated, then adjustments need to be made in order to complete the second implementation plan. Because the Commission uses percentages, adjustments are more easily made unless the situation is so extreme as to warrant significant realignment. In the case where OAPP feels there will be a significant gap in funding, the issue is brought back to the Commission. Any such adjustments prompt a new implementation plan.

- A key limitation is that Case Watch was not a centralized data system until the beginning of this contract year. It will take a few years before the data is fully accurate. It is improving and validation checks support accuracy of current clients and services, though agency accuracy in input and timeliness will remain a critical component. Meanwhile, data is manually tabulated and explains the periodic delays in providing the Commission with requested information. While CaseWatch has its limitations, it is still among the best in the country. Mr. Ballesteros asked about duplication of clients. Dr. Green responded that eventually it will be possible to check that, including whether a client may be accessing the same service under more than one Title, but that data is not yet available.
- Health outcomes improvement is also an area that will need to be documented for HRSA. There will be analysis capability with CaseWatch as time goes on. Mr. Engeran asked if data might be used to identify service categories that are generating strong health outcomes. Dr. Green responded that is a goal that will eventually assist the Commission with expected outcomes from specific service categories. Dr. Frye noted that the electronic version of HIV/AIDS Reporting System (HARS) will permit more data, like more than three CD4s, allowing for serial reporting of a case to evaluate outcomes. The CDC is encouraging that, though legislation permitting it would be required in California.
- Dr. Green agreed with Dr. Frye that unmet need data can become a more complex issue in a data-rich environment. Those who know their status but are not in care were listed as 7 points in the last application, which is high. However, if it were shown that some of these were accessing other sources of care, the allocation to meet the need would decrease. Mr. Vincent-Jones said it was questioned in the Cross-Titles Collaboration why HARS and CaseWatch cannot be used in conjunction with one another to obtain a better estimate of unmet need. Dr. Green responded that the lack of names-based reporting makes it impossible to unduplicate the numbers. By comparison, in St. Louis viral load and CD4s are mandatorily reported by name. He added that St. Louis also compared services with the state's Medicare/MediCal, as well as the VA. He noted that they found a 20% overlap with Medicare/MediCal, though part of that is from people transitioning systems. The fee-for-service rate structure will also provide a much more precise ability to measure what services the client is receiving for the funds expended.

XV. **REVISED COMPREHENSIVE CARE PLAN INTRODUCTION**: Ms. Watt and Mr. Land introduced the revised plan with a PowerPoint on the Strategic Planning Process. Ms. Watt noted that this is the basic process that has been presented several times over the course of the process.

- Ms. Watt recalled the importance of the paradigms and operating values that will be utilized throughout the process. She called particular attention to the paradigm of equity, especially important in an era of shrinking resources. She also emphasized the importance of keeping in mind the need to think about the entire County in planning to support a unified system. A unified system also means that the relationship between prevention and care needs to be addressed.
- Mr. Land said the Commission received a letter earlier this year requesting a revised Comprehensive Care Plan by December 31, 2005. While the entire process, guided by the Strategic Plan, will not be complete until April or May, parts of the Plan have been enhanced or updated. The revised version will be submitted. Enhancements include composite narratives provided by Dr. Long.
- Next Steps provide a "Where Are We Going" section with 10 clear goals; a "How Are We Going To Get There" section with objectives and implementation plans; a "How Will We Monitor Our Progress" section with the newly developed standards and outcomes/indicators; and a section of Work plans. The data collection will include portions of the Table 3 discussed earlier, though integrating all the data is planned. The objectives are a theme for the plan. This living document, he further explained, reflects the development of enhanced data and more focussed work.

XVII. **STRATEGIC PLANNING PROCESS**: Ms. Burbie introduced the process.

A. Current Decisions:

- The work group revisited the needs assessment data to ensure key issues would remain at the forefront.
- Paradigms and operating values were chosen.
- The vision and mission statements were crafted to be shared among the partners, with each participating according to their role.
- The goal is to seek a viable, effective plan for the next five years.
- The group respected the importance of not attempting to craft the final plan, but to provide a framework for the partners to contribute fruitfully to it.
- The work today is to participate as a stakeholder, as well as to encourage other stakeholders to participate.
- By the end of December, it is hoped that stakeholder focus groups will be complete.

- The group will then bring together the input from the various stakeholder groups and craft a document to go back out for stakeholder review.
- Input from the review will then be incorporated by the group into the final document.

B. Next Steps:

- The focus groups today will begin with a discussion of the ideal in order to encourage creative thinking about the issues.
- Keeping the ideals in mind, the current realities will be addressed.
- It is important for everyone to engage in open discussion, stimulating each other to challenge the issue and bring depth to the issue.
- Each person should bring his/her authentic experiences to the discussion, from life perspectives and experiences, to County politics to provider interactions.
- The stakeholders should ask questions to draw out others.
- The group then broke into four discussion groups for the remainder of the day.

XIX. **ADJOURNMENT**

A. **Roll Call:** The meeting adjourned at 5:00 to dinner.

DAY 2: NOVEMBER 15, 2005			
MEMBERS PRESENT	**MEMBERS PRESENT *(cont.)***	**PUBLIC**	**COMM STAFF/ CONSULTANTS**
Al Ballesteros, *Co-Chair*	Susan McGinnis	Richard Eastman	Virginia Bonila
Nettie DeAugustine, *Co-Chair*	Quentin O'Brien		Diane Burbie
Ruben Acosta	Everado Orozco		Gary Garcia
Carla Bailey	Dean Page	**OAPP STAFF**	Jane Nachazel
Anthony Braswell	Angelica Palmeros		Arlene Narvaez
Carrie Broadus	Gloria Perez	Chi-Wai Au	Glenda Pinney
Robert Butler	Wendy Schwartz	Michael Green	Elizabeth Ramos
Charles Carter	James Skinner	Jan King	Lisa Ransdell
Mario Chavez	Ron Snyder	Juhua Wu	Doris Reed
Alicia Crews-Rhoden	Gary Vrooman		Deborah Silver
Whitney Engeran	Kathy Watt		Jim Stewart
Hugo Farias			Beverly Voran
Douglas Frye	**MEMBERS ABSENT**		Craig Vincent-Jones
William Fuentes			Nicole Werner
David Giugni	Adrian Aguilar		
Terry Goddard	Daisy Aguirre		
Elizabeth Gomez	John Griggs		
Jeffrey Goodman	Marcy Kaplan		
Richard Hamilton	Carlos Peralta		
Precious Jackson	Andrew Signey		
Brad Land	Jonathan Stockton		
Kevin Lewis	Peg Taylor		
Anna Long	Jocelyn Woodward		
Davyd McCoy	Fariba Younai		

I. **REGISTRATION/CONTINENTAL BREAKFAST**: Commissioners and participants began converging in the meeting room at 8:30 am.

II. **CALL TO ORDER**

A. Roll Call/Introductions: Ms. DeAugustine and Mr. Ballesteros called the meeting to order at 8:45 am. Mr. Vincent-Jones conducted the role call.

III. **WELCOME**

A. Agenda Review: Ms. DeAugustine complemented the Commission on the previous day's work. She added the dinner was also both enjoyable and an opportunity to get to know each other better as people. Mr. Ballesteros offered a special thank you and encouragement to new Commissioners.

IV. **PUBLIC COMMENT, NON-AGENDIZED**: There was no non-agendized public comment.

V. **COMMISSION COMMENT, NON AGENDIZED**: There was no non-agendized Commission comment.

VI. **STRATEGIC PLANNING FOCUS FORUM**

A. Small Groups: Ms. Burbie complemented the focus groups. She noted four people from the group she was with the day before had said the discussion had stimulated thoughts about something they already had in the works in another arena or agency. That shows the value of the process in developing new approaches to these issues.

B. **Large Group Report-Out**:

- **Question 2**: Clarified "traditional" as "non-CARE Act". Felt expertise in wholistic would permit effective partnering, including advocacy for HIV services. Suggested "Aged, Blind and Disabled" be expanded to include "Chronically Ill". Also felt "barriers" need to include "gender, language, race, geography and societal conditions like social networks and environments". Noted education of service providers important. Multi-service centers encouraged. A case management model was suggested to enhance continuity for the client. Prevention could integrate most easily, and Medi-Cal/Title X models of women and family health care are models that could benefit quickly from integration. There was concern about loss of specialized knowledge, as well as competition for funds from other disease populations.
- **Question 3**: It is difficult to determine for the County as a whole due to different geographic needs. Desire to move away from need assessment to asset mapping. Important to empower and fund providers to bundle services for better service to their area clients. Three models proposed depending on conditions: WalMart, mini-mall and boutique. Client centered multi-service center with services housed together. One-stop shopping should be centered on client need as opposed to geography. Emphasis on treating the whole person. Important to continue specialty services, but also important to physically and psycho-socially co-locate them. For ease of use, efficiencies through information technology and administrative consolidation as possible. Concerned that referrals not always helpful, especially in some service areas like housing. The Centers of Excellence hub-and-spokes model would encourage better inter-provider communication.
- **Question 4**: It was assumed that there would be more limited funding, either directly or proportionately. Emphasized better use of available funding from whatever source, e.g., faith-based funds. All providers should participate in advocacy. Market a wellness model. Funding can be better leveraged by working more closely with other public funding streams like SAMSHA. Look at reducing service duplication. Use small demonstration project to utilize broad range of funding streams to test viability for County. Review efficiency of SPAs in coordinating services. Empower SPAs to move beyond HIV. The biggest challenge is good leadership. Engage providers and consumers in planning, mergers and coalitions. Is the number of HIV service providers appropriate or are some redundant. Support collaboration regarding both internal and external through either incentives or mandates, e.g., for RFPs. Support co-location of services and administration efficiencies. Attract funding not necessarily attached to HIV.
- **Question 5**: Stigma is a key barrier in accessing care, especially in regards to providers that scream "HIV" rather than being a site for routine care that doesn't label a client as HIV+. New and effective ways to access populations who do not know they are positive, emphasizing care for the whole person to reach those not focussed on HIV care. Key barriers are lack of knowledge by police, social services, the community and other agencies of the structural, organizational and individual barriers to care. Tailor education to populations not normally accessed, e.g., outreach to grocery store patrons. Use technology better, like investing in mobile case management system. Ongoing leadership training is needed to enact new proposals effectively. The system creates its own bottleneck because it was originally designed for short-term care and tends to trap people in a situation where they have more care than needed but cannot leave without losing care still required. Advocacy can address the bottleneck through making the system more flexible and responsive to need, e.g., making it easier to return to work part-time without losing benefits.
- **Question 6**: A re-emphasis on peer-to-peer education can help people acclimate to routine care. Go beyond current contract models to ensure providers are meeting current needs, e.g., ensure providers are funded for non-traditional BRG populations. Humanize services, e.g., a voicemail requesting name and number for anonymous testing is discouraging. Reconsider tone of public service announcements. Incorporate testing into routine medical care. Define "into care" as a personal decision and provide needed support for the client to make that decision throughout that system. Provide mentoring for the newly diagnosed, e.g., help in making and getting to appointments. Some testing locations do not provide post-testing information and could promptly be enhanced with it.
- **Question 7**: Encourage providers to educate each other in order to better know when and how to create linkages and referrals. Leveraging non-HIV specific funds can help develop linkages. There is little collaboration even among care and prevention. The SPAs and Coordinated Provider Networks need more authority to follow-through with collabora-

tive. The CARE Act began as a primary care model and appears to be returning toward that model, but it is important to maintain the flexibility to address issues like HIV+ women wishing to become pregnant or someone addicted to crystal meth. It's important to maintain the non-primary care services as entry points into the system of care. Closer monitoring of agencies, some of which do not provide the care they are contracted to provide, would free funding for more effective services. Other chronic diseases have developed models of care that can be adapted quickly to HIV.

B. **Collaboration**: Ms. Burbie called attention to the recurrence of themes of collaboration, coordination and linkage among all forms of services. That underlines the need for the Strategic Plan to address all stakeholders, not just the Commission. She noted that the work group has had difficulty in engaging the broader range of collaborators. She asked the group to address that question.

- Ms. DeAugustine supported going one-on-one to stakeholders, as was done successfully in educating stakeholders about the Comprehensive Care Plan. Encourage dialogue with the stakeholders based on the premise of mutual collaboration for the benefit of all. All providers can engage other providers serving their clients.
- Stakeholders can be encouraged to re-imagine funding streams, rather than segregating each from the other.
- Ms. Broadus said much of the substance abuse community originally felt substance abuse should not be treated as a disease with harm reduction rather than incarceration, but shifted quickly to participate in Proposition 36.
- Me. Butler looks forward to taking the revised Comprehensive Care Plan on the road to engage people and see that it is to their benefit to participate.
- Mr. Land said it is important to learn others' concerns, including the situation of Public Health reorganization.
- Mr. Chavez said it was important to demonstrate cost-effectiveness and good quality of care to stakeholders.
- Mr. Lewis felt there was insufficient movement going forward. For example, the City of Los Angeles 2003 White Paper identified recommendations that have never been implemented. He finds that discouraging. He would like to hear an action item. Mr. Vincent-Jones said he has seen over his four+ plus years that the Commission has routinely been a source of new ideas. The purpose of the strategic planning process is precisely to break the insular circle and engage those outside the Commission. With ideas as broad-ranging as reconfiguring the health care system, it is necessary to have a consistent process to bring out the ideas in a reviewable form to other stakeholders in order to engage them and ultimately win their participation in the reconfiguration. He anticipates that it will gain momentum.
- Ms. Watt said HIV is one of the youngest social service systems in the County but, nevertheless, are perceived as one of the richest and one of the least willing to work collaboratively. That perception must be changed from the inside out.
- Mr. Giugni recommended asset mapping as a means of identifying how funding streams might be better aligned. In the course of developing that, stakeholders can come to recognize its value to them.
- Mr. Land noted Ms. Palmeros had suggested marketing to the stakeholders.
- Ms. Bailey said it was important to keep evolving along with the nature of the epidemic.
- Ms. Broadus recommended non-affiliated consumers to better link quality and access of care with service units. She added that "Chronically Ill" is now the major population, rather than the "Disabled", and the system needs to address it.
- Business planning, rather than strategic planning, may be the better model, including the political aspect of service.
- Ms. Palmeros has been working in SPA 3 to link provider services. She has interns taking area mapping photographs and presented to the City of Pasadena to win support, noting that increased services will reduce the transient population. She finds it important to work at the connections with strong documentation and outcomes that will be valuable for all.
- Mr. Braswell noted the development of standards of care is also a major accomplishment that took time to reach generation of the standards, but is now halfway completed. Despite that and other accomplishments, he noted that nothing will be of value if reauthorization and funding issues are not addressed.
- Ms. Burbie assured everyone that all the thoughts generated by the groups will by carried forward to the Strategic Planning Committee. Ideas that recurred among groups underline the strength of consensus on that item. She encouraged Commissioners who might know someone who would be of value at the table to talk with Mr. Vincent-Jones or Ms. Pinney and assist in engaging the nominee(s) in the process.
- The key new idea emphasized was addressing how to interlink the specialized HIV system of care with the mainstream system. Inevitably, it will begin to happen. The choice is whether to act or react.

X. **ANNOUNCEMENTS**: Mr. Eastman reported on the Campaign 2 End AIDS which culminated Washington, DC. It included a march and "die-in". The event was successful with over 500 people participating.

XI. **ADJOURNMENT**: Mr. Ballesteros complemented the process, the Commission and Ms. Burbie's facilitation. Ms. DeAugustine thanked everyone and adjourned the meeting at 5:00 pm, on Day 2, November 15, 2005.

MOTION AND VOTING SUMMARY		
MOTION #1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2: Approve the minutes from the October 13, 2005 Commission on HIV meeting.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3: Introduce the Conflict of Interest Policy/Procedure for 30 days Public Comment	***Passed by Consensus***	**MOTION PASSED**
MOTION #4: Recommend that the Board of Supervisors and the Department of Health Services (DHS) reject the proposed service reductions, as detailed in communications by the Office of AIDS Programs and Policy (OAPP), and instruct DHS and OAPP to develop an alternative solution within 30 days (for presentation by the next Commission meeting on December 8, 2005), based on a thorough analysis of all of the administrative items.	**Aye**: *Bailey, Butler, Carter, Crews-Rhoden, Fuentes, Giugni, Goodman, Land, Orozco, Pérez, Schwartz, Skinner* **No**: none **Abstain**: *Ballesteros*, DeAugustine*, Engeran*, Farias*, Gomez* Hamilton*, Kaplan*, Long, Palmeros*, Signey** ****From impacted agencies***	**MOTION PASSED** **Ayes**: 12 **Opposed**: 0 **Abstention**: 10
MOTION #5: As a Priority- and Allocation-Setting measure, and unrelated to recommendations in response to proposed Year 16 contract reductions, recommend that the Board of Supervisors and the Department of Health Services (DHS) instruct the Office of AIDS Programs and Policy (OAPP) to provide the Commission on HIV, within 30 days, OAPP's current fiscal year operational budget, ending June 30, 2006. Further, OAPP should be instructed to provide all associated documents, projections, process and methodology used in the creation of the subsequent FY budget beginning on July 1, 2007. This should include relevant OAPP contracted information from all parts of the CARE Act, NCC, cooperative agreements and other sources of funds.	**Aye**: *Bailey, Ballesteros*, Butler, Carter, Chavez*, Crews-Rhoden, DeAugustine*, Engeran*, Farias*, Fuentes, Giugni, Gomez*, Goodman, Hamilton*, Kaplan*, Land, Orozco, Palmeros*, Pérez, Schwartz, Signey*, Skinner* **No**: none **Abstain**: *Long* ****From impacted agencies***	**MOTION PASSED** **Ayes**: 22 **Opposed**: 0 **Abstention**: 1
MOTION #6: Approve the Consolidated Statement on CARE Act Reauthorization in conjunction with the State's planning councils.	***Passed by Consensus***	**MOTION PASSED**
MOTION #7 ***(Engeran/Butler)***: Instruct the P&P and Finance Committees to continue monitoring the Medicare Plan D situation and fully develop cost recovery scenarios, and for staff to work with OAPP to develop an implementation plan and recommendations by the December 8, 2005 Commission Meeting.	***Passed by Consensus***	**MOTION PASSED**